



STATE OF IDAHO

BUREAU OF OCCUPATIONAL LICENSES

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Dear Licensee:

Congratulations on your licensure as a Licensed Master Social Worker. As an LMSW you are eligible to begin the process toward licensure as a Master Social Worker qualified for Clinical Social Work.

To obtain Clinical Licensure you must be on record as receiving formal supervision. When you desire to begin the process toward clinical licensure, complete the attached application and return it to the Board of Social Work Examiners. CREDIT FOR SUPERVISION CANNOT BEGIN UNTIL THE COMPLETED APPLICATION AND SUPPORTING MATERIAL HAS BEEN RECEIVED.

**APPLICATION FOR APPROVAL OF PRIMARY SUPERVISOR and
PRIMARY SUPERVISION PLAN FOR CLINICAL LICENSURE**

This application is to notify the Board of Social Work Examiners of my intent to begin the supervision required for clinical licensure. I understand that all supervision must be provided by a clinically licensed Social Worker, clinically licensed Psychologist, Psychiatrist, or a licensed Clinical Professional Counselor registered as a supervisor or a Marriage and Family Therapist registered as a supervisor. I further understand that information and materials necessary to start the supervision process will be sent to me and that my supervised experience may not commence until my supervisors are registered and the Board approves my supervision plan.

Supervisee Name _____

License Number _____ Social Security # _____

Primary Supervisor Name _____

License Number _____ Social Security # _____

Mailing address _____
Street/PO Box City State Zip

Business address _____
Street/PO Box City State Zip

Phone _(____)_____ E-mail _____

PRIMARY SUPERVISION PLAN

1. How often will supervision be provided and for what duration?

2. Please explain the nature of the supervisory relationship. Is supervision being contracted for or is it being provided within an agency framework?

**APPLICATION FOR APPROVAL OF PRIMARY SUPERVISOR and
PRIMARY SUPERVISION PLAN FOR CLINICAL LICENSURE**
(continued)

3. Briefly describe the nature of the clinical work that will be performed.

AFFIDAVIT

We the undersigned hereby agree to participate in the supervision required leading to Clinical Licensure in Social Work in the State of Idaho. By signing this document we acknowledge that we understand the requirements and procedures necessary for such supervision and will participate in the developed plan for appropriately satisfying those requirements.

Signature of Primary Supervisor

Signature of Candidate for Licensure

State of _____, County of _____, ss.

State of _____, County of _____, ss.

Subscribed & sworn before me this _____

Subscribed & sworn before me this _____

day of _____, AD _____

day of _____, AD _____

Notary Public Official Signature
my commission expires _____

Notary Public Official Signature
my commission expires _____

(SEAL)

(SEAL)

The Board will notify candidates of approval of supervision plan within 10 days of receipt.

**APPLICATION FOR APPROVAL OF SECONDARY SUPERVISOR and
SECONDARY SUPERVISION PLAN FOR CLINICAL LICENSURE**

(Supervisor must be a clinically licensed Social Worker, clinically licensed Psychologist or Psychiatrist or licensed clinical professional Counselor registered as a supervisor or a licensed Marriage & Family Therapist registered as a supervisor.)

Supervisee Name _____

License Number _____ Social Security # _____

Primary Supervisor Name _____

License Number _____ Social Security # _____

Secondary Supervisor _____

License Number _____ Social Security # _____

Mailing address _____
Street/PO Box City State Zip

Business address _____
Street/PO Box City State Zip

Phone _(____)_____ E-mail _____

SECONDARY SUPERVISION PLAN

4. How often will supervision be provided and for what duration?

5. Please explain the nature of the supervisory relationship. Is supervision being contracted for or is it being provided within an agency framework?

**APPLICATION FOR APPROVAL OF SECONDARY SUPERVISOR and
SECONDARY SUPERVISION PLAN FOR CLINICAL LICENSURE**

(continued)

6. Briefly describe the nature of the clinical work that will be performed.

AFFIDAVIT

We the undersigned hereby agree to participate in the supervision required leading to Clinical Licensure in Social Work in the State of Idaho. By signing this document we acknowledge that we understand the requirements and procedures necessary for such supervision and will participate in the developed plan for appropriately satisfying those requirements.

Signature of Secondary Supervisor

Signature of Candidate for Licensure

State of _____, County of _____, ss.

State of _____, County of _____, ss.

Subscribed & sworn before me this _____

Subscribed & sworn before me this _____

day of _____, AD _____

day of _____, AD _____

Notary Public Official Signature
my commission expires _____

Notary Public Official Signature
my commission expires _____

(SEAL)

(SEAL)

The Board will notify candidates of approval of supervision plan within 10 days of receipt.